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## **Chapter 6**

### **Slipping into ‘That Nurse’s Dress’:**

#### **Caring as Affective Practice in Mixed-Sex Couples’ Relationships**

##### **Introduction**

Sometimes, like in that photograph of our morning when he’s still asleep, and I’m reading, then I sometimes kiss and cuddle him. But that nurse’s dress, I start wearing it immediately after we get out of the bed.

In this quotation, Kristiina<sup>1</sup>, a woman I interviewed for my doctoral dissertation (Sointu 2016), describes a moment in bed before she rises and starts the day. Her partner suffers from advanced Alzheimer’s disease. On some days he recognizes Kristiina, and on other days he does not. He could not manage living at home without her constant care.

What initially caught my attention in Kristiina’s account was the metaphor of the nurse’s dress. In many ways, this metaphor captures what it means to provide care to one’s partner at home on a daily and nightly basis. It points to the embodied dimension of having responsibility for care while simultaneously living together at home as a couple. The metaphor implies wearing a uniform. I interpret it to refer to different aspects of managing embodied care, such as controlling one’s tone of voice, facial expressions and ways of touching, which are needed to maintain the calmness and good spirits of the partner whose relation to the world has been altered by dementia.

In research, this kind of activity has been analysed as emotion work in both formal (e.g. Hochschild 1983; James 1992; Twigg 2000) and informal care settings (Thomas, Morris & Harman 2002). Yet in the context of family the notion of work is somewhat problematic, as it fades out the distinctive features of intimacy in family relations (Twigg *et al.* 2011:173). Thus, there is a need for novel concepts to analyse the everyday realities of informal care that acknowledge the complexities of emotion, embodiment, power and intimacy in family relationships.

In this chapter, I suggest that the concept of affective practice offers a useful tool for broadening our understanding of care in intimate relationships. Drawing from Margaret Wetherell's (2012, 2015) concept of affective practice combined with Patricia Benner and Suzanne Gordon's (1996) concept of caring practice, I further develop the conceptual apparatus with which to approach care in the context of intimate relationships.

Conceptualizing caring as affective practice allows us to conceive of caring as an activity that entails personal, sentient, thinking and feeling involvement without assuming that these feelings and sentiments are always positive, or that they are individual possessions or characteristics of those who engage in them. Moreover, the concept of affective practice brings together the sentient/embodied and the discursive without assuming that either precedes the other (Wetherell 2012). Most importantly, conceiving of caring as affective practice enables us to grasp how the dynamics of a care relationship are also dynamics of power and take place in a mesh of affective inequalities.

Drawing from interviews with older people whose partners have fallen ill with dementia, I focus on how they make sense of what has happened to them as they have taken up caring, and how they have settled into the affective practice of caring. As the focus is on affect, it is crucial not to lose sight of the embodied and sensory aspect of becoming engaged with the practice of caring. For this purpose, I draw from sensory methodology (Mason & Davies

2009) in collecting and interpreting the data.

I start the chapter by elaborating the idea of caring as affective practice, drawing from care research and Margaret Wetherell's (2012) concept of affective practice. Next, I present the methodology of this study. The subsequent three sections are empirical, and focus on the process in which a mixed-sex couple relationship turns into a care relationship. Finally, I present the main conclusions and contributions to research on care in intimate relationships with an emphasis on discussions that concern power as an integral element of the care relationship (Dominelli & Gollins 1997; Lynch, Lyons & Cantillon 2009; Milne & Larkin 2015:8; Simplican 2015; Twigg 2000).

### **Caring as Affective Practice**

I suggest that the concept of affective practice offers a useful tool for examining care, since it addresses some of the key characteristics of caring as a social activity. In particular, it helps us to understand how caring for a spouse with dementia involves operating in and through inherent affective inequality within the relationship. The imbalance of power in the care relationship arises from the premise that without another person's help, the one who needs care would not survive. This makes the one who needs care vulnerable and dependent on the caregiver. For this reason, providing care for a person who is unable to fulfil her basic needs has been called caring for dependents (Wærness 1984:189), to separate it from other forms of care that lack the backdrop of physical, social and psychological dependency (cf. Conradson 2003; Cooper 2007).

Dementia threatens the emotional and practical safety of the person who has fallen ill. Care, therefore, is needed to ensure that the person who suffers from dementia still eats, drinks and is safe, both physically and emotionally. Because dementia ultimately involves loss of meanings, social conventions and a coherent sense of self, creating an atmosphere that

maintains emotional safety is particularly important when providing care for a person with dementia (Evans & Lee 2014; Schillmeier 2009). The position of caregiver is intrinsically a position of power, as through her responses the caregiver can either maintain or disrupt the safety of the person with dementia.

Care researchers have pointed out that providing care involves the personal engagement of the caregiver, who needs to utilize embodied and situated knowledge rooted in the relationship (Benner & Gordon 1996:45; Graham 1983; Hamington 2004; Mason 1996; Wærness 1984). Sociologist Kari Wærness (1984) developed what she called the rationality of caring, the idea that caring for dependent persons involves a particular kind of rationality to which the actor as a sentient being is integral. Later, Jennifer Mason (1996) introduced concepts such as sentient activity and active sensibility. With them Mason aimed to shift the focus, from conceiving of feeling and thinking as individual states of a caregiver's mind towards an understanding of feelings as part of the caring activity embedded in relations between people. Yet Mason did not explore in detail how in the activities of caring the sentient elements, namely thinking and feeling, entwine with the norms and discourses that guide how family members should relate to each other.

This is why the concept of practice is useful: it enables us to understand single actions, feelings and thoughts as part of wider arrays of actions, personal histories, norms and cultural understandings (Schatzki 2001; Wetherell 2012:12–13). In conceptualizing caring as affective practice, I draw from Patricia Benner and Suzanne Gordon's (1996:43–44) take on caring practice as a 'culturally constituted, socially embedded way of being in a situation and with others'. Caring practice consists of embodied actions, feelings or sentiments, and responses, arrayed together for the purpose of contributing to another person's well-being. In order to respond to the care need, the caregiver interprets the care receiver's embodied appearance, such as facial expression and gestures, and responds to them in her own

embodied appearance (Hamington 2004). These embodied responses, however corporeal, are nevertheless based on a more or less shared cultural understanding concerning appropriate responses in that situation.

The interconnection of corporeal responses and discourses in caring can be clarified by a more recent take on the concept of practice by Margaret Wetherell (2012). Her concept of affective practice helps to elucidate how affect and discourse intertwine in the practice of caring. According to Wetherell (2012:13–14), ‘in the affective practice, bits of the body [...] get patterned together with the feelings and thoughts, interaction patterns [...] and interpretative repertoires, social relations, personal histories, and ways of life.’ In other words, appropriate embodied responses to care needs are not defined solely in the interaction of two people; instead caregivers engage in a practice that is informed by discourses.

These discourses concern the appropriate, desired and required affective responses in the context of care and couple relationships. On the one hand, living with a spouse who has dementia is informed by discourses concerning care and what it means to be caring. To be caring, for example, is to embody such qualities as patience and selflessness as personal characteristics (Skeggs 1997:67–68). These norms are circulated in the education for formal care workers, and increasingly also for informal carers (Winch 2006). On the other hand, living together as spouses is informed by discourses concerning adulthood and companionship in a couple relationship. In a couple relationship, partners are usually relatively autonomous when it comes to such basic tasks as taking care of personal hygiene and eating. Although in reality partners are far from autonomous and self-sufficient, this norm nevertheless stands out as an important premise for adulthood. These and other norms become negotiated over time in each relationship, with a unique history (Wetherell 2012:96). Caring as affective practice is thus embedded in the history of the couple, however long or brief. The shared history persists as memories and habitual ways of being together (Smart

2007).

Through the analysis of care as affective practice in intimate relationships, this chapter adds to the feminist critique that has aimed to decouple the concept of care from romanticized notions of care as ‘a labour of love’ (Cooper 2007; Kelly 2017; Mason 1996; Simpican 2015). Perceiving care as a labour of love—as something people do in families and intimate relationships out of love and devotion for each other—leaves aside fundamental aspects of the care relationship. One such aspect is power. Although power was understood as constitutive of care relationships even in early care research (Wærness 1984), the significance of power dynamics has nevertheless been neglected in empirical research on informal care. Thus far, discussions of power in the care relationship have concentrated on formal care (Dominelli & Gollins 1997; Lee-Treweek 1996; Twigg 2000). In informal care, the discussion has circled around whether the caregiver or the care receiver has authority and control in the relationship (e.g. Lynch *et al.* 2009). There is a lack of understanding concerning the dynamics of power in the care relationship (Dominelli & Gollins 1997:412; Simpican 2015:225).

In the analysis I focus on how the affective practice of caring emerges in concrete embodied encounters between partners. Through close reading of caregivers’ interviews, I illustrate how one of the central tensions apparent in caregivers’ narratives of the early days of care concerns the changing power dynamics. Whereas the focus in this chapter is on the early days, I suggest that this tension is inherent and continuous in the affective practice of caring where family relationships are concerned.

### **Sensory Methodology of the Research**

This chapter is derived from a larger project in which I studied everyday lives of older informal carers in Finland. For the study, I interviewed fifteen persons between fifty-nine and

eighty-two years of age living in mixed-sex marriages and giving care to their partners at home on a long-term basis (Sointu 2016). The interviewees' spouses all needed constant care, assistance and attention, for which the interviewees had responsibility at the time of the interviews. For this chapter, I have chosen interviews with seven interviewees (six women and one man) whose partners had been diagnosed with advanced dementia and whose partners' care needs had emerged gradually. Their stories illustrate poignantly the tensions that arise with the onset of the affective practice of caring.

Because affective practice by definition involves the body, it is important not to lose sight of the sensory aspects of experiences expressed in the interview talk. For this purpose, I drew from sensory methodology (Mason & Davies 2009) in collecting and interpreting the data. This is a research strategy that is 'attuned to the complex ways in which the senses are tangled with other forms of experience or ways of knowing' (Mason & Davies 2009:587). The idea is to tease out, in different phases of the research, sensory experience and knowledge. In the data collection, this approach implies using methods to evoke reflection on the sensory that might not always be easy to verbalize in a more traditional interview setting. Photographs are one such stimulus that has been a particularly useful way to evoke such reflection (Harper 2002; Mason & Davies 2009).

In this study, I used photographs taken by the participants and other stimuli as part of the interviews to elicit detailed talk about the lived and sentient experience of caring (Harper 2002; Sointu 2016). Initially I planned to carry out photo elicitation with all the participants, but not everyone felt comfortable with or capable of taking up the task. Therefore, I decided to use whatever stimuli the participants brought into the interview situation. Of the interviews used in this chapter, in four the photographing task was used; other stimuli included poems written about the loss of a husband, photographs taken to demonstrate to one's friends the extremity of one's everyday life, a guidebook for relatives about dementia, and a care-themed

written autobiography.

In the data analysis in this study, attuning to the sensory involves reading the interviewees' narratives as told by sentient beings about their concrete surroundings. In analysing the transformation of a couple relationship into a care relationship, I pay attention to embodied encounters and reflections, concrete aspects of everyday living, and the affective textures of being together at home and living as a couple whose lives have been upended by illness and need of care. I interpret the affective practice of caring as embedded in these affective textures and mundane activities (cf. Wetherell 2012:4).

While I find Wetherell's (2012) concept useful for bridging the sentient and the discursive in the practice of caring, my methodological approach differs significantly from hers. Instead of focusing on situated interaction in naturally occurring situations like Wetherell, I analyse how people make sense of what has happened to them in interview talk. I assume the interviewees' talk to express their personal experiences of what it has meant for them to become caregivers for their spouses. I read the interviewees' accounts as reflecting their personal experience, which also contains conflicts and tensions originating from societal power relations (McNay 2004). Although my analysis does not focus on situated interaction, I wish to retain the idea of the situational as the limit to my interpretation. By this I mean that even though the interviewees' relationships with their partners are now significantly organized around care, there are still dimensions in their relationship that are beyond the scope of care and beyond this study. The transformation of the couple relationship into a care relationship is not necessarily all-encompassing.

Through narrative analysis (Polkinghorne 1995) of the caregivers' accounts, I construct a narrative organized around a central tension arising between the ideals of two (supposedly) equal adults and the requirements of the new circumstances in which one partner depends on



the other for care. I further suggest that this tension—and its constant resolution in everyday encounters with the partner—remains central to the affective practice of caring, even after initial settling. I focus on the activities and tensions involved in the process in which the couple relationship becomes a care relationship.

### **Becoming Unsettled: Emerging Awareness of Care Needs**

As the interviewees look back on the time they later perceive as the early phase of care, they describe a period of gradually growing confusion, irritation, worry, frustration and anger regarding their partners. Ulla, a sixty-six-year-old woman, for example, recalls that her husband little by little stopped taking care of what had been ‘his duties’ at home, such as renovating the house. In addition, he sometimes did things that deeply upset her. For example, once, while gardening, he cut flowers that were very dear to her. At the time, her husband’s action in the garden seemed like an intentional attempt to hurt her, as she had no idea that her husband might be incapable of taking her feelings into account due to the onset of dementia.

The stories of the early phase of care convey a sense of becoming unsettled in two ways. The first concerns habitual ways of being together. A couple who live together for years, sometimes decades, accumulate knowledge of each other’s characters, habits, personality and ways of doing things. In addition, they establish conventions and rules for how things are done in the household and how partners may treat each other (Smart & Neale 1999:69; Wetherell 2012:121–122, 129). The interviewees’ narratives reflect the breakdown of habitual ways of being and living together in various ways. Kaarina, a woman aged sixty-six, describes how, in addition to paying attention to what she calls ‘small oddities’, she noticed how her husband began to ‘vanish’. She refers to his changing embodied appearance: ‘it was very rare that he had any expression on his face any more,’ she recalls. For Helena, a sixty-

five-year-old woman, the most upsetting disruption had been her husband's changing personality: 'he got angry more often than before, and he was easily irritated. And of course I didn't know that he was sick, he hadn't been diagnosed yet, so I yelled and gave him orders and threw tantrums. I often found myself shouting at him: "what the heck are doing!"' The interviewees' narratives express the growing puzzlement and distress they sometimes sense in their bodies. Ulla, for example, tells how she used to—and sometimes still does—experience palpitations if her partner did not follow her instructions.

Secondly, the balance of power within the couple's relationship becomes unsettled. The power balance is challenged by the partner's care need, which is not yet perceived as a care need. Awareness arises as a feeling of worry or irritation over the partner's actions or appearance. Soile, a sixty-six-year-old woman, recalls those early days:

It was about that time I first got nervous [shows a photo of a middle-aged man with an expressionless face]. I guess we both thought that he had cancer because he had begun to lose weight. [...] I didn't notice it because he had always eaten in the evening, and I had eaten in the morning. And we were both of mature age when we got together, so there was no reason to change our habits. So it took a while until it dawned on me that he was losing weight because he had stopped eating. We went to the grocer's together, but I didn't always pay attention to what he bought.

Soile's story illustrates how the need for care disrupts the couple's status quo. Needing help to fulfil such basic needs as eating implies dependence on another person (Wærness 1984). This unbalances the relationship between spouses and creates tension. For Soile to become aware of her husband's care need, she has to pay attention to him in ways that can be regarded as intrusive.

Through their rising worry and irritation, the interviewees slowly become aware of what is

happening in their lives. Growing unsettlement is actually the first step towards the affective practice of caring, as it contributes to one's becoming aware of the partner's care need. The balance of power begins to shift and creates tension in their everyday dealings. Those tensions intensify when the caregivers begin to take more conscious actions to help.

### **Settling into the Affective Practice of Caring**

In the next phase of the story, interviewees discuss the difficulties after they finally become aware that the partner is in fact sick and in need of help. At this point, the caregivers attempt to interfere in their spouses' personal affairs in various ways. David Conradson (2003:508) has suggested caring should be conceived as the caregiver's movement towards the one needing care in response to rising need. In light of this idea, I interpret interfering in the partner's personal affairs as an attempt to move towards the care need. However, at this point, these efforts are hesitant and illegitimate, as they question the partner's authority as an independent adult. As Soile puts it: 'I'm not used to giving care to adults, but when I noticed the situation, I tried to begin to give care.'

This phase of the story reflects the difficulties in altering the habits and conventions of a couple relationship. The inability to move generates frustration. Pentti, a man aged seventy, describes this situation: 'she has changed little by little, but she resists and says, "I don't have this disease. I don't want to have this disease!" Then you get this terrible feeling. [...] How will we manage and live with this thing?' Pentti's account of his wife's unwillingness to comply with the identity of a person with a serious illness illustrates how the affective practice of caring involves both parties of the relationship. Coming to terms with long-term care needs is not only about changing the caregivers' mindset. Responding to the care need requires that the partner, at least to some degree, consents to the sick role in everyday dealings and interactions. Yet complying with the sick role can be threatening because it

questions one's authority over one's own life. The early stage of dementia can be a confusing and frightening experience as one slowly loses control over mundane and obvious matters.

The difficulties in moving towards the care need do not arise exclusively from the partner's resistance. They also connect to how interfering in the partner's decision-making means contravening the norm according to which adults usually perform certain activities independently. As such, the source of the difficulties can be found in the caregivers' attempts to cross the boundaries of acceptable treatment of one's partner. These boundaries are set by discourses that stipulate what two adults, even those who share an intimate relationship, should do for each other (Parker 1993). Deciding on behalf of another person about matters such as eating, sleeping and visiting the doctor questions the partner's authority and independence in matters usually understood as each adult's own responsibility. Yet needing care inevitably means that one is, to an extent, incapable of caring independently for oneself (Isaksen 2002; Twigg 2000).

As the caregivers engage with the affective practice of caring, they find themselves manoeuvring through these conflicting discourses. Here it is evident how the sentient and the discursive intertwine in the practice of caring (Wetherell 2012, 2015). In the interviewees' accounts, the conflict often culminates in attempts to get the partner to agree to go to the doctor. For example, when fifty-nine-year-old Kristiina, whose husband has Alzheimer's disease, first suggests going to the doctor and having a memory test, her husband becomes angry and accuses her of treating him as a 'lunatic'. Attempting to interfere in one's partner's affairs is questionable in the context of a couple relationship. Once the caregiving partners perceive themselves and their partners in the context of a care relationship, however, they find it easier to make decisions and act in certain ways in relation to the partner. Helena's remark illustrates this transition:

There was a time when I said to him that because you're so mean, and you do all these nasty things, I do not want to grow old with you. You can live your life as you will, and I will leave and be on my own. I felt sad that it would all end like that. But then fortunately, he got the diagnosis that he had dementia. [...] You should not get stuck in thinking and insisting that you have a spouse. You won't cope that way. I wouldn't have coped that way.

Perceiving the relationship as a care relationship enables one to tolerate behaviour that does not comply with the ideal of how spouses should treat each other. This is illustrated in Helena's account of how the threat of divorce is dissolved with the diagnosis. Perceiving the relationship as a care relationship also enables one to undertake actions that would be (morally) questionable in the context of a couple relationship. Kristiina, for example, states that she tells 'white lies' to keep her husband calm. She states that it is acceptable to lie to him now that he is sick, whereas earlier in the relationship, honesty was a given.

### **Getting in and out of the Nurse's Dress**

The interviewees' accounts of how they come to care for their partners communicate a change in their understanding of their partners, themselves and their relationship. In many ways, the change entails letting go of the expectations and conventions of a couple relationship. In the caregivers' narratives, this change is seen as a necessary condition for assuming responsibility for the partner's care. As part of this responsibility, the caregivers pursue affective states that they consider appropriate and compatible with the purposes of caring, such as patience, tenderness and calmness. For example, Helena, who has attended a course on how to interact with a person with dementia, talks about the importance of her voice: '[tone of voice] is one of the most important things. If I'm tired, and I say something with a snappy tone of voice, he flinches. So irritation is really contagious. It is something that

you really have to try to get out of your system.’ Similarly, Kristiina says that she tries to ‘keep her mouth shut’ and Oili that she attempts to ‘swallow her anger’ in order not to show their irritation to their respective husbands. Both expressions refer to concealing feelings of anger from the partner by managing one’s appearance. Moreover, the interviewees reflect on the connection between their inner state and communicating with their partners. Kristiina and Ulla, for example, both ponder in the interviews how they feel that they should use more touching to calm their husbands down, but they find it difficult if they feel irritated. Ulla says that if she is in a ‘very good mood’, then she might go and hug her husband.

These difficulties illustrate how the shift to a care relationship does not mean a complete break with life as a couple. Although managing one’s emotions and affective expressions is important in the caregivers’ everyday lives, they do not transform into ideal types of caregivers who have no feelings of their own. Even if the interviewees to some extent come to terms with their partners’ constant need for monitoring and care, they still occasionally struggle with feelings of sadness, irritation and anger while relating to their partners. Here we return to the metaphor of the nurse’s dress. In Kristiina’s account, the dress is not on constantly. The way she slips in and out of the dress illustrates how the practice of caring is never completed. Instead, the continuous pursuit of certain affective states is an important part of the caring practice.

In these pursuits, the bodily appearance of the partner is also important. Some interviewees find it difficult to maintain the idea that the partner really is sick and in need of care if their partner’s physical appearance remains untouched by dementia. For example, Kristiina connects her ‘uncaring’ feelings, such as anger, with difficulties in perceiving her husband as sick:

I tend to lose my temper, and then I curse and shout. Because the thing is, he appears

physically as if he is okay. It's hard to get it in your head that he's sick. Then you just throw a tantrum at him. I don't know how to get into the thought that he really isn't all right because he looks all right. I think it would be easier if he had something more visible.

So far, I have considered the shifting power balance in the relationship as if a couple relationship were a relationship of two equals to start with. That, of course, is not always—if ever—the case. For example, Oili, an eighty-two-year-old woman, describes having suffered psychological abuse from her husband throughout her marriage. She has stayed in the marriage out of a sense of duty and attachment that has deepened over the years, despite the abusive elements. She reflects that her husband's dementia has turned the power balance upside down. Finally, she is the one capable of hurting her husband, who is now helpless and dependent on her:

Oili: I've thought about how this ambivalence in our marriage might be reflected in the caring relationship. This is what I have been thinking. We have all these difficulties, and they can be reflected in the caring work. But I don't know—I have tried being patient with him, but still I'm afraid that it might be reflected.

Me: What do you mean, that they might be reflected?

Oili: Well, I mean that I would never—I'm afraid that if I sometimes flare up so badly, that I might do something, hurt him. This is what I'm afraid of. But I haven't flared up.

Oili's story illustrates that the past weaves into the affective practice of care in complex ways. Here the past creates an unstable—even threatening—foundation for caring. In situations like these, the caring practice requires careful balancing between providing care

and giving treatment that can be close to mistreatment or abuse (cf. Twigg 2000). Oili's story shows how, even though the affective practice of caring becomes more settled over time, unbalanced power still remains a central dynamic of the affective practice of caring in some ways. In situations like that described by Oili, this dynamic can become a source of affective inequality for both parties in the relationship.

## **Conclusions**

In this chapter, I have analysed activities and tensions in the process of a couple relationship becoming a care relationship. Focusing on caring as affective practice in the early phase of care, I have found that a central tension arises from the shifting power dynamics in the intimate relationship. To respond to the partner's care need requires exercising power in ways that differ from both the ideals and the lived realities of a couple relationship. The caregivers find themselves manoeuvring through conflicting discourses that set limits on how partners should treat each other. Finding a resolution of this tension by conceiving of the relationship as a care relationship makes it easier for the caregivers to find appropriate sentient, emotional and embodied responses to the partner's care need. Yet, even after this initial resolution, it seems that affective inequality remains an integral underlying tension, constantly waiting to be resolved in everyday encounters with the partner.

Based on my analysis, I suggest that the concept of affective practice is especially useful in research concerned with the everyday lives of older couples. This is because the concept of affective practice opens a view on how personal, sentient, thinking and feeling involvement in providing care is entangled with discourses that regulate appropriate involvement (Wetherell 2012). The concept also captures the ambivalences of power relations inherent in the caring practice. By offering an account of caring as affective practice, this chapter contributes to calls for conceptual approaches with which to shed light on care from a non-



idealizing perspective, acknowledging the complex dynamics of power in care (Dominelli & Gollins 1997; Kelly 2017; Lynch *et al.* 2009; Milne & Larkin 2015:8; Simplican 2015; Twigg 2000). The concept of affective practice offers one way forward to analyse care in intimate relationships without losing sight of societal power.

This study raises concerns about how inequality is mediated affectively in the context of informal care and intimate relationships. These concerns relate to how and why older couples end up in informal care situations, and whether they have the opportunity to arrange long-term care in other ways. In Finland, as in many other mature welfare states, the restructuring of public elder care services over the past thirty years has increasingly returned responsibility for care to families (Kröger & Leinonen 2012). In the absence of affordable and reliable care services, couples and families may have no choice but to arrange care informally at home.

Yet forced care creates a hazard situation for both caregivers and care receivers. Intense neediness and vulnerability affect intimate relationships in ways that can sometimes be erratic, inflicting tensions that cannot be completely avoided in even the most harmonious relationships. Unresolved issues from the past may create hazard situations for care, as illustrated in this chapter. Forced care is a significant form of affective inequality for both parties in the intimate relationship. At worst, the caregiver's suffering in providing care might contribute to abuse and violence towards the care receiver. Presently the issue of violence and abuse in care policy remains completely unacknowledged, at least in Finland.

This study raises a concern about the trend towards formalizing informal care. Currently informal care is becoming increasingly formalized as European welfare states increasingly introduce schemes to support informal carers (ed. Ungerson & Yeandle 2007). In addition to government action, informal carers' organizations have become important in arranging peer support. There are positive elements in these trends: for example, through public support the

gendered nature of previously hidden and undervalued informal care work, mainly performed by women, becomes increasingly acknowledged.

Yet these tendencies also carry elements that might become a source of affective inequality. Both government action to support informal care and peer activity contribute to growing awareness, norms and standards of what it means to be a good carer (Heaton 1999; Pickard 2010; Winch 2006). This chapter has demonstrated how such personal matters as using one's voice may become an object of self-reflection and self-regulation as part of the affective practice of caring. It is worth considering what kinds of norms about good care are reasonable, so as not to add extra pressure in a demanding life situation.

Furthermore, more research is needed to shed light on the consequences of the increasingly formalized informal care for everyday experiences, practices and intimate relationships. Approaching care as affective practice might be useful in future research, as this concept directly addresses the interplay of sentient, personal and intimate elements in care as they become entwined with discourses and societal power.

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